

## Instructions for the ARNP Registration Application

The Kentucky Nursing Laws (KRS 314.042) defines the advanced registered nurse practitioner (ARNP) as an individual registered and designated to engage in advanced registered nursing practice including, but not limited to, the nurse anesthetist, nurse midwife, nurse practitioner, and clinical nurse specialist. **Registration is required to practice as an ARNP in Kentucky. If you practice as an ARNP in Kentucky without registration, you will be subject to disciplinary action.** Practice inconsistent with the specialty standards of your certifying body may also be subject to disciplinary action. No nurse shall indicate by practice or words that he/she is an ARNP unless so registered by KBN.

All applicants for ARNP registration must complete a post-basic educational program that meets the requirements stated in 201 KAR 20:056, *ARNP Registration, Programming Requirements, Recognition of a National Certifying Organization*. Note: Some educational programs preparing clinical nurse specialists do not meet the requirements. Your transcript will be reviewed to validate the requirements have been met.

All applicants for ARNP registration must have a current, active Kentucky nursing license or temporary work permit and have completed an organized post-basic program of study and clinical practice. The program must be approved by the appropriate national certification organization.

**Application fees and requirements are subject to change. Application fees are non-refundable.** The current application fee is \$120, payable by check or money order, and is valid for a period of one year from the date the application is received in the KBN office. Boxes are provided on this instruction sheet for you to mark those areas of the application that you have completed.

**Applicants for registration as an ARNP are required to complete the following sections:**

### Complete Sections

All Applicants	1, 2, 3, 4, 6
Reinstatement	1, 2, 3, 4, 5, 6

## Section 1: Biographical Data

- ☐ Using black ink and capital letters, clearly print your name, address, and all other information requested. **If the name on your application differs from your name on any other documents submitted with this application, you must include a copy of legal name change documentation with this application.** You are required to notify the KBN office of any subsequent legal name and/or address change within 30 days.

## Section 2: Designation/Type and Method of Application

- ☐ Darken the circle to indicate the appropriate ARNP designation type.

## Section 3: ARNP Educational Program Information

- ☐ Please answer all questions in this section. If your ARNP designation is a clinical specialist or a nurse practitioner, select the type(s) that applies to you. If your designation type is not listed, write the type on the line provided.

## Section 4: National Certification or Recertification

- ☐ **To be eligible for registration as an ARNP, you must hold a national certification/recertification OR have made application and be eligible to take an initial certification examination.**
- ☐ If you hold a current advanced nursing practice certification with a national organization, please answer "yes," insert the month and year the certification expires, and indicate the organization from which you received the certification. If the organization is not listed, write the organization's name on the line provided. **YOU MUST INCLUDE A COPY OF THE CERTIFICATION WITH THIS APPLICATION.**
- ☐ If you do NOT hold a current certification, answer "no," insert the month and year you will be taking the certification examination and indicate the organization from which you will receive the certification. If the organization is not listed, write the name of the organization to which you have applied. **See next page.**

## Section 4: National Certification or Recertification (continued)

☐ If you do NOT hold current certification but have applied for national certification, you must complete the following forms:

☐ **Verification of Eligibility and Application for Certification Examination**  
Send this form to the national certifying organization to which you have applied and request that they submit it directly to the KBN office.

☐ **Verification of Supervision**  
Complete the top portion of the form and give it to your employer and request that it be mailed directly to the KBN office.

### TEMPORARY AUTHORIZATION TO PRACTICE

Upon submission of the required application documents, a temporary authorization to practice may be issued to those applicants who have registered for the certification examination. **A temporary authorization is NOT available to those who have allowed a previous ARNP registration to lapse or those who have not applied to take a national certification examination.**

## Section 5: Reinstatement of a Kentucky ARNP Registration

☐ **Complete this section ONLY if you held an advanced registered nurse registration in Kentucky, the registration expired, and you wish to become registered in Kentucky again.**

**A COPY OF YOUR CURRENT NATIONAL CERTIFICATION/RE-CERTIFICATION MUST BE SUBMITTED WITH THIS APPLICATION.**

## Section 6: Notary

☐ All applications must be notarized. Do not sign the application until you are in the presence of a Notary Public. Read this section carefully as you are held legally responsible for the truthfulness and validity of the information you provide on this application.

## Photograph

☐ Attach a passport photograph in the space provided. The photograph must be taken no more than six months prior to the date the application is notarized. Print your name on the back of the photograph in case the photograph should become separated from the application.

## Additional General Requirements

☐ **NAME CHANGE:** Legal documentation of name change if documents are in different names.

☐ **TRANSCRIPTS:** Transcripts sent directly from the school/program to the Kentucky Board of Nursing are required for all ARNP applicants.

**(1) ARNPs applying for reinstatement, and**

**(2) Nurse anesthetists: If your program awarded a diploma or certificate, you must send a copy of that document to KBN.**

☐ **COLLABORATIVE PRACTICE AGREEMENT:** An ARNP with a Collaborative Practice Agreement for prescriptive authority must maintain a copy of the agreement. **Do NOT send a copy to KBN unless you are requested to do so.**

**APPLICATION FOR REGISTRATION AS AN  
ADVANCED REGISTERED NURSE PRACTITIONER**

Office Use Only

**APPLICATION FEE IS NON-REFUNDABLE**

**Print clearly using capital letters and black ink. Refer to instruction sheet before completing this application.**

**Section 1: Biographical Data**

Last Name:	<input type="text"/>	Male:	<input type="radio"/>
First Name:	<input type="text"/>	M.I.:	<input type="text"/>
Maiden Name:	<input type="text"/>	Female:	<input type="radio"/>
Street Line 1:	<input type="text"/>		
Line 2:	<input type="text"/>		
City:	<input type="text"/>	State:	<input type="text"/>
Zip:	<input type="text"/>	County of Residence:	<input type="text"/>
SS #:	<input type="text"/>	Daytime Phone #:	<input type="text"/>
Date of Birth:	<input type="text"/>	Home Phone #:	<input type="text"/>

**Section 2: Designation/Type of ARNP Registration Requested**

**If you seek licensure as an RN and registration as an ARNP, you must file a separate application for each.** Darken the circle below for the appropriate ARNP registration type requested.

ARNP Specialty Type: Anesthetist (Cd A3) ☐ Midwife (Cd M4) ☐ Practitioner (Cd P5) ☐ Clinical Specialist (Cd S6) ☐

**Section 3: ARNP Educational Program Information**

Please answer the following questions about the advanced practice nursing program you attended. **See the instruction sheet for transcript requirements.**

Office Use Only

PON Code:

**Advanced Practice Nursing Program Information: (Name of School)**

Name:	<input type="text"/>	
City:	<input type="text"/>	State: <input type="text"/>
Month & Year Entered:	<input type="text"/>	Month & Year Graduated: <input type="text"/>
Did program include a supervised clinical practicum?	Yes <input type="radio"/> No <input type="radio"/>	Degree/Credential Earned: <input type="text"/>

**Office Use Only**

TWP Dates: \_\_\_\_\_ To: \_\_\_\_\_ TA Letter: \_\_\_\_\_ TR Letter: \_\_\_\_\_ RN Status Code: \_\_\_\_\_

Approved for Registration: On \_\_\_\_\_ By \_\_\_\_\_

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### Section 3: ARNP Educational Program Information (continued)

Advanced Practice Program Type:

**Anesthetist (Cd 1)**☐**Midwife (Cd 2)**☐**Clinical Specialist**☐

Select Type

**Nurse Practitioner**☐

Select Type

Adult Psychiatric/Mental Health (Cd 10) ☐Child/Adolescent Mental Health (Cd 11) ☐Community Health (Cd 15) ☐Gerontological (Cd 13) ☐Medical/Surgical (Cd 9) ☐

Other (List) \_\_\_\_\_

Acute Care (Cd 14) ☐Adult (Cd 3) ☐Family (Cd 4) ☐Gerontological (Cd 7) ☐Neonatal (Cd 12) ☐Pediatric (Cd 5) ☐School (Cd 8) ☐Women's Health (Cd 6) ☐

Other (List) \_\_\_\_\_

### Section 4: National Certification or Recertification

**The Kentucky Board of Nursing requires all applicants to either hold advanced practice certification/recertification, or to have applied for that certification. You are responsible for sending KBN a copy of your certification/recertification card. This must be received before you will be registered as an ARNP. YOU MAY NOT WORK AS AN ARNP IN KENTUCKY UNTIL YOU HAVE A CURRENT, ACTIVE REGISTRATION.** Please answer the following:

Do you hold an advanced nursing practice certification with a national organization? **Yes** ☐ **No** ☐

If yes, month and year your certification/recertification expires:

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(Attach a copy of the certificate with this application.)

If you do NOT hold advanced nursing practice certification, have you applied to a certifying organization? **Yes** ☐ **No** ☐

If yes, month and year you will be taking the certification examination:

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Indicate the organization from which you hold advanced nursing practice certification or to which you have applied:

American Academy of Nurse Practitioners

☐

National Certification Board of Pediatric Nurse Practitioners &amp; Nurses

☐

American Nurses' Credentialing Center

☐

American College of Nurse-Midwives

☐

National Certification Corporation

☐

American Association of Nurse Anesthetists

☐

Other (List) \_\_\_\_\_

### Section 5: Reinstatement of a Kentucky ARNP Registration (\$120 Fee Required)

**Answer the questions in this section only if you were previously registered as an ARNP in the Commonwealth of Kentucky. You must enclose: 1) a copy of your most recent national certification form an organization listed in Section 4, and 2) the \$120 application fee.**

Has your national certification ever been revoked or issued on a provisional/conditional status?

**Yes**☐**No**☐

If yes, you must submit an accompanying letter of explanation.

**Section 6: Notary - All Applications Must Be Notarized**

I certify that I am the person referred to in the foregoing application for registration as an advanced registered nurse practitioner in the Commonwealth of Kentucky and who is pictured in the enclosed photograph; that all statements contained herein and on all attachments are true and correct in every respect; that I have read and understand this application and all requirements stated therein. I further understand that all information on this application is subject to an audit for verification and that the falsification of any information contained herein will be cause for disciplinary action.

**Signature of Applicant**

Subscribed and sworn to before me by

on this date:

 -  - **Signature of Notary Public**

State of

My Commission Expires

S E A L

**Make check or money order payable to:  
Kentucky Board of Nursing**

**\$120 FEE IS NOT REFUNDABLE  
AND IS SUBJECT TO CHANGE**

**If all requirements for registration are not met within  
the time period required by regulation, a new application  
must be submitted with the required fee.**

**Passport Photograph**

This space to contain a recent  
passport photograph.

Picture must fit in this area.

Only passport photos will be  
accepted.

Tape photo in this section.

Print your name on the back of  
your photo.



## Additional Signatures

### Supervising ARNP

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY RN License #

\_\_\_\_\_  
ARNP #

### Supervising Physician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY License #

### Supervising ARNP

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY RN License #

\_\_\_\_\_  
ARNP #

### Supervising Physician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY License #

### Supervising ARNP

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY RN License #

\_\_\_\_\_  
ARNP #

### Supervising Physician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY License #

### Supervising ARNP

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY RN License #

\_\_\_\_\_  
ARNP #

### Supervising Physician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY License #

### Supervising ARNP

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY RN License #

\_\_\_\_\_  
ARNP #

### Supervising Physician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
KY License #

## Employer Comments

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**Please disregard if currently certified by a national organization for advanced nursing practice.**